PREVENTING SUBSTANCE-RELATED HARMS AMONG YOUTH THROUGH A COMPREHENSIVE SCHOOL HEALTH APPROACH

A BLUEPRINT FOR ACTION

October 2020



# Introduction

Schools are an important context for youth.[[1]](#footnote-1) They are a setting for learning, personal and community development, socialization and the promotion of health and well-being. The COVID-19 pandemic has underscored the significance of school communities in the lives of young people and their families, as well as their central place in society more broadly. In recent years, there has also been greater attention on the role of schools in addressing substance use and substance-related harms among youth.

At the same time, there have been major advancements in our understanding of substance use topics, reflecting growing evidence on the factors that contribute to substance-related harms and promising practices for intervention,[[2]](#footnote-2) including those designed for and by youth. This evidence is being used to shape interventions in various settings. However, there is an opportunity to better integrate evidence-based approaches to preventing substance-related harms in the context of school communities.

Purpose

The main purpose of this resource is to provide guidance that can help to **inform comprehensive and concrete action plans and strategies** at various levels of the Canadian education system (i.e., individual schools, school boards, school health organizations, etc.) to prevent substance-related harms among youth. Specifically, this resource is intended to facilitate a approach that reflects the diverse realities and needs of students, the varied determinants of substance use and substance-related harms, and the many areas in which schools can take action.

This resource is a call for school communities to **think differently about how they approach youth substance use**. In light of resource limitations, it is in school communities’ best interest to invest in school health initiatives that are both effective and equitable. This means shifting away from approaches that lack empirical support and embracing a wide range of initiatives that supported by evidence. It also means recognizing that “one-size-fits-all” models do not resonate with, and often exclude many youth, and that models that reflect youths’ diverse needs, identities and situations are needed. Likewise, school-based efforts to prevent substance-related harms must reflect school communities’ unique needs, resources, culture, values and the social and health challenges they face.

This resource is also intended to **support school stakeholders in engaging their networks, communities and governments for increased attention, buy-in and resources for comprehensive and long-term approaches for preventing substance-related harms among youth**. School-based efforts to prevent substance-related harms among youth are not just “nice to haves”; these efforts work to protect and promote the rights of youth, in accordance with various international treaties (e.g., the United Nations Convention on the Rights of the Child). As such, these efforts very much fall within the “lane” of school communities. However, as outlined in this accompanying policy paper on youth substance use [LINK], substance-related harms are incredibly complex and a public health problem that cannot be addressed through “quick fixes”. This is why action to prevent substance-related harms among youth must be both immediate and ongoing, as well as multi-prong and collaborative.

Audience

The primary audience for this resource is members of Canadian school communities. This includes those working within the education system (e.g., administrators, school board officials and other decision-makers, teachers, guidance counsellors, volunteers, health promotion practitioners, public health nurses, etc.), students, families and community organizations that support youth. These groups are integral to planning, implementing and sustaining efforts to prevent substance-related harms.

The secondary audience for this resource is the broader array of Canadian school stakeholders. This includes government officials and researchers working in substance use and school health, school and public health organizations and organizations representing priority populations of youth and their allies (e.g., Indigenous and LGBTQ2+ youth). These stakeholders have a vested interest in the health and well-being of youth. They can directly or indirectly advocate for and support equitable, evidence-based initiatives to prevent substance-related harms, both within school communities and other settings.

Overview of the Blueprint for Action

This resource includes three sections.

**Section 1** outlines four key messages that represent the Blueprint’s main “take-aways”. **Section 2** presents a new model meant to help school communities in planning and carrying out efforts to prevent substance-related harms. This section provides a high-level overview of the various components of this model: the framework and four evidence-based approaches for addressing substance use issues. The section concludes by “zooming out” on the model, examining how its components fit together and the value of integrating various approaches within prevention efforts. Finally, **Section 3** describes the application of the model in practice, including facilitators and barriers to applying the model in practice. Section 3 concludes by outlining some cross-cutting principles for action.

How this resource was developed

This resource was developed through engagement with Canadian school stakeholders. Much of the content reflects discussions and activities that took place during *School Matters: Building a Blueprint for Action for School Communities to Help Prevent Substance Use Harms*, a two-day forum convening over fifty diverse school stakeholders in February 2020 in Toronto, Ontario. Participants included youth/students, administrators, researchers, government officials, school health professionals, teachers, members of community organizations, parents and Indigenous peoples from across Canada. The Public Health Agency of Canada (PHAC) co-hosted the forum with three other national organizations: the Canadian Centre on Substance Use and Addiction, Canadian Students for Sensible Drug Policy and Joint Consortium for School Health. The forum focused primarily on secondary school contexts, although many forum participants underscored the need for complementary interventions at other school levels.

Throughout the forum, participants shared their knowledge, ideas and perspectives on youth substance use, various intervention approaches and school health. These contributions greatly shaped this resource, as well as an accompanying policy paper [LINK]. Participants were also invited to provide input on both of these publications. We are grateful for their ongoing engagement in this work.

# Section 1: Key Messages

[To be developed by the Students Commission of Canada through the Mobilizing the Blueprint contract]

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| **Key message #1:** |
| **Key message #2:** |
| **Key message #3:** |
| **Key message #4:** |

# Section 2: The Blueprint for Action intervention model

This section presents and unpacks the Blueprint for Action intervention model. The Blueprint model is meant to support school community members in planning and carrying out a wide range of strategies for preventing substance-related harms among youth that:

* are **grounded in evidence (including practice-based evidence[[3]](#footnote-3))**,
* reflect **students’ diverse needs and contexts** (including with respect to substance use) and
* **maximize the many levers**[[4]](#footnote-4) school communities can use to support health and well-being.

The Blueprint for Action model (shown in **Figure 1**) brings together the Comprehensive School Health framework, an effective and well-established model for informing action on school health matters, and four evidence-based approaches to preventing substance-related harms: upstream prevention, harm reduction, stigma reduction initiatives and equity-oriented approaches. These approaches and the Comprehensive School Health framework are defined and unpacked later in this section.

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|  |  | **Substance Use Intervention Approaches** | | | |
|  |  | **Upstream prevention** | **Harm reduction** | **Stigma reduction** | **Equity-oriented interventions** |
| **Comprehensive School Health Framework Components** | **Teaching and Learning** |  |  |  |  |
| **Social and Physical environment** |  |  |  |  |
| **Policy** |  |  |  |  |
| **Partnerships and Services** |  |  |  |  |

**Figure 1.** The Blueprint for Action model for planning and enacting comprehensive school-based interventions to prevent substance-related harms.

Much of the available literature and resources on school-based initiatives related to youth substance use focus solely on a particular *intervention* *approach* and/or *lever*. For example, several publications describe best practices for harm reduction-focused drug education, an in doing so, provide evidence on a particular approach (harm reduction) and lever (education). However, these publications rarely acknowledge how education can be used as part of a more comprehensive and coordinated approach to preventing substance-related harms (e.g., by educating students and staff on substance use stigma, supporting students in developing key socio-emotional skills through school curricula, etc.). As a result, many of the existing resources available provide a useful, though relatively narrow, perspective on the range of actions school communities can take to address youth substance use.

In light of these limitations, the Blueprint model was designed to showcase several evidence-based approaches, outline the many ways they can be carried out within school communities and describe how initiatives can fit together to support youths’ well-being and prevent substance-related harms.

This section unpacks the various aspects of this model. It begins with an overview of Comprehensive School Health, followed by a snapshot of each of the four intervention approaches. The snapshots provide “need-to-know” background information on each approach, as well as examples of how they can be operationalized in concrete ways using the Comprehensive School Health framework.

## Comprehensive School Health

Comprehensive School Health is an internationally-recognized and holistic approach to building healthy school communities. The approach can be used to guide the planning, carrying out and evaluation of school initiatives related to various aspects of health.

Comprehensive School Health has been widely adopted in Canada and in various formats, ranging from local school action plans to provincial/territorial school health strategies. Evaluations of the approach in these various settings demonstrate its effectiveness in improving youths’ health, social and educational outcomes and reducing health inequities, and that these benefits can be long lasting.

The pan-Canadian Joint Consortium for School Health developed a framework to represent the Comprehensive School Health approach (**Figure 2**). The framework encourages school communities to act across four inter-related components that compose the whole school environment when assessing or implementing an intervention:

1. **Social and physical environments**, including the relationships among and between staff and students; school culture; buildings, grounds and recreation space in and around the school; spaces designated to promote student safety and connectedness; etc.;
2. **Teaching and learning**, including formal and informal curricula and resources; professional development opportunities for staff related to health and well-being; student and staffs’ knowledge, understanding and skills related to health and well-being, etc.;
3. **Policy**, including policies, guidelines and practices that promote and support students’ health, well-being and achievement and foster a respectful, welcoming and caring school environment for all members of the school community, etc.; and
4. **Partnerships and services**, including connections between school staff and students’ families; supportive working relationships among and between schools and community organizations; partnerships between health and education sectors; community and school-based services that support and promote student and staff health and well-being, etc.



**Figure 2.** The Joint Consortium for School Health’s Comprehensive School Health Framework.

The Comprehensive School Health framework can help to guide and strengthen efforts within school communities related to substance use. **Box 1** shows examples of Canadian resources that describe the usefulness of the framework for meaningfully preventing substance-related harms among youth.

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| **Box 1.** Canadian resources on addressing youth substance use using Comprehensive School Health.  In 2009 the Joint Consortium for School Health and the Canadian Institute for Substance Use Research released a resource series called [*Addressing Substance Use in Canadian Schools*](https://www.jcsh-cces.ca/index.php/resources/tools-toolkits). The series centres on Comprehensive School Health and features topics on substance use policy and education, school-family-community partnerships and responding to the needs of marginalized youth. The series emphasized the goal of *reducing substance-related harms* (i.e., rather than *promoting abstinence*), the importance of social-emotional learning and the need to use a *range* of levers (not just substance use education) to address substance use concerns.  In 2014 the Canadian Centre on Substance Use and Addiction developed the [*Canadian Standards for Youth Substance Abuse Prevention*](https://www.ccsa.ca/sites/default/files/2019-05/2014-CCSA-Canadian-Standards-Youth-Substance-Abuse-Prevention-Overview-en.pdf)*,* which includes guides for community, family and school contexts. *The Building on our Strengths: Standards for Prevention in Schools* guide focuses on prevention initiatives and acknowledges the need for a Comprehensive School Health approach. The guide describes the importance of meeting youth “where they are at” through prevention efforts. The guide also shares practical guidance on addressing sustainability, conducting evaluations and other considerations for designing school substance use initiatives. |

A key benefit of the Comprehensive School Health framework is that is not prescriptive and allows school communities to be nimble and adjust their plans as contexts and needs change (i.e., as they did when many Canadian school communities shifted to online means of communication, teaching and learning, delivering programming, etc. during the COVID-19 pandemic). The framework can also help school communities to think through how they can translate *conceptual* approaches to addressing substance use into practical and concrete school-based actions and identify the assets and gaps within their school community relevant to the identified school-based action(s). This is illustrated in the “snapshots” of upstream prevention, harm reduction, stigma reduction initiatives and equity-oriented interventions detailed below.

## Upstream Prevention

Upstream prevention is an approach to addressing health issues that has recently gained ground in school communities (see **Box 2** for detail on the origins of the term “upstream”). Upstream prevention is closely related to “health promotion” since upstream prevention can support positivesocial and healthoutcomes (e.g., social connectedness, autonomy, etc.), as well as lower the likelihood of negative outcomes (e.g., substance-related harms)*.* Upstream efforts aim to address the “root causes” of a health issue or behaviour, particularly by boosting protective factors while minimizing risk factors.

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| **Box 2.** What do we mean by “upstream”?  The term “upstream” comes from the classic public health “river parable”. While walking alongside a river, a witness sees someone caught in the current. The witness jumps in the river and saves the person from drowning, only to see another person caught in the river in need of rescue. This continues for some time until the witness has saved many people and is completely exhausted. **The witness then decides to walk upstream to see why so many people are falling into the river *in the first place* to see if they can help there instead.**  The parable illustrates the value of identifying and acting on the factors that can lead to people “fall into the river” (i.e., experiencing or being at a high risk of harms). This is the focus of upstream prevention interventions. Keeping with the river analogy, upstream prevention is often contrasted with “downstream” interventions. Downstream interventions are equally necessary and seek to prevent harm when they have already occurred to some extent or appear imminent (i.e., when people have already “fallen into the river”). Examples include efforts to improve access to substance use treatment or protocols for responding to a suspected overdose. |

Picture a balance scale. Protective factors, like healthy relationships, a strong sense of self, access to high quality education, a safe environment and school and community connectedness, promote overall health and well-being. These protective factors can counterbalance the negative impact of risk factors, such as poverty, food insecurity, social isolation and experiences of trauma, abuse, stigma and discrimination (e.g., racism, homophobia, ableism, etc.), which may increase the likelihood of substance-related harms. The balance of risk and protective factors on the scale, particularly during early life, can have a significant impact on a person’s health and well-being. Often these outcomes – either positive or negative, depending on the balance of the scale – can take years or even decades to surface.

[CREATIVE SERVICES TO INSERT IMAGE HERE]

The scale analogy shows the importance of upstream efforts that work to achieve a greater balance of protective factors relative to risk factors within a child’s life. Fortunately, there are many powerful protective factors within school communities. These include healthy, supportive relationships between students and adults within the school and a high degree of school connectedness. These and other protective factors can be bolstered by actions big and small within schools. Even relatively simple things, like creating safe, inclusive spaces for youth and demonstrating a genuine interest in students’ interests and goals, can go a long way in reducing their likelihood of experiencing substance-related harms.

Upstream prevention can be carried out through specific school-based programming. A notable example is “positive youth development” programs, which have been implemented widely in Canada and elsewhere. Central to these programs is the view that youth are individuals with inherent strengths and infinite potential, as opposed to individuals with problems that need to be solved. Positive youth development programs provide teachers with training, guidance and strategies that can help to enhance students' well-being, socio-emotional skills and positive mental health. By boosting these important assets, positive youth development programs can help reduce the likelihood of substance-related harms, as well as poor mental health, bullying, violence and other negative factors.

Effective upstream prevention can look different “in action” from one school community to the next, depending on the unique risk and protective factors in those contexts and the resources available. These differences will have implications for what school communities prioritize and act to address. For example, a school community in an urban centre may prioritize increasing opportunities for healthy recreation and leisure for students by building partnerships with local organizations (e.g., photography groups, anime clubs, etc.), while a school community in rural and remote community may prioritize programming that shares information on and celebrates Indigenous culture. In fact, the process of identifying and addressing a community’s unique risk and protective factors is central to the “Icelandic model”, an upstream prevention model related to substance use that has been applied in communities in over 30 countries internationally, including Canada, and has shown promise in many jurisdictions.

As these examples demonstrate, upstream efforts are often not explicitly linked to substance use, unlike substance use policies or education. Indeed, proponents of the upstream approach to addressing youth substance use say, “the best prevention measures often have nothing do with substance use at all”.

The figure below lists examples of specific school community-based upstream prevention-oriented initiatives, across the four components of the Comprehensive School Health framework. For more on upstream prevention efforts in school communities, please refer to PHAC’s resource series [*Preventing problematic substance use by enhancing student well-being*](https://www.canada.ca/en/public-health/services/beyond-health-education-preventing-substance-use-enhancing-students-well-being.html)*.*

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|  | **Upstream prevention** |
| **Teaching and Learning** | * Weaving social-emotional learning into various classroom curricula to enhance students’ skills related to self-awareness, empathy, communication, self-regulation and conflict resolution, etc. * Prioritizing health education through course allocations and scheduling with an aim to enhance students’ knowledge, attitudes and skills related to aspects of a healthy lifestyle (e.g., sleep, nutrition, stress management, positive mental health, physical activity, consent, etc.). * Creating or strengthening curricula designed to improve students’ health (including mental health) literacy skills, including their ability to find, appraise and understand health information. |
| **Social and Physical environment** | * Promoting and expanding the range of extra-curricular programming available to students (e.g., intramurals, events and clubs) to reflect students’ diverse interests and identities. * Enabling students to create and decorate safe, inviting and inclusive communal spaces within the school for them to use during breaks in the day. * Facilitating opportunities for adults within the school community (e.g., teachers, coaches, Elders/Knowledge Keepers, etc.) to serve as formal or informal mentors, providing youth with guidance and social and emotional support. * Establishing a universal school food program that encourages staff and students to come together in a welcoming, inclusive environment to socialize and share a meal or a snack. |
| **Policy** | * Assessing existing school policies, including the school’s vision and mission statement, to identify how these policies work to facilitate students’ overall health and well-being and work towards a favourable balance of risk and protective factors for substance-related harms. * Developing and enforcing policies that foster a safe and inclusive school climate for all, while discouraging bullying, harassment, stigma and discrimination in its various forms. * Outlining in policy expectations that youth are compensated, through financial or other means, for their time leading and contributing to school initiatives. |
| **Partnerships and Services** | * Facilitating and promoting diverse part-time work and volunteer opportunities for students within community organizations or events (e.g., local food banks, community bicycle co-ops, arts and culture festivals, code-a-thons, etc.). * Developing partnerships between schools and community athletics and recreation centres to increase the accessibility and availability of programming and services for youth (e.g., by offering reduced rate workshops, hosting an open house for students and their families, etc.). * Inviting local partners into the school for various events, such as a wellness activity or art performance for the students. |

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## Harm Reduction

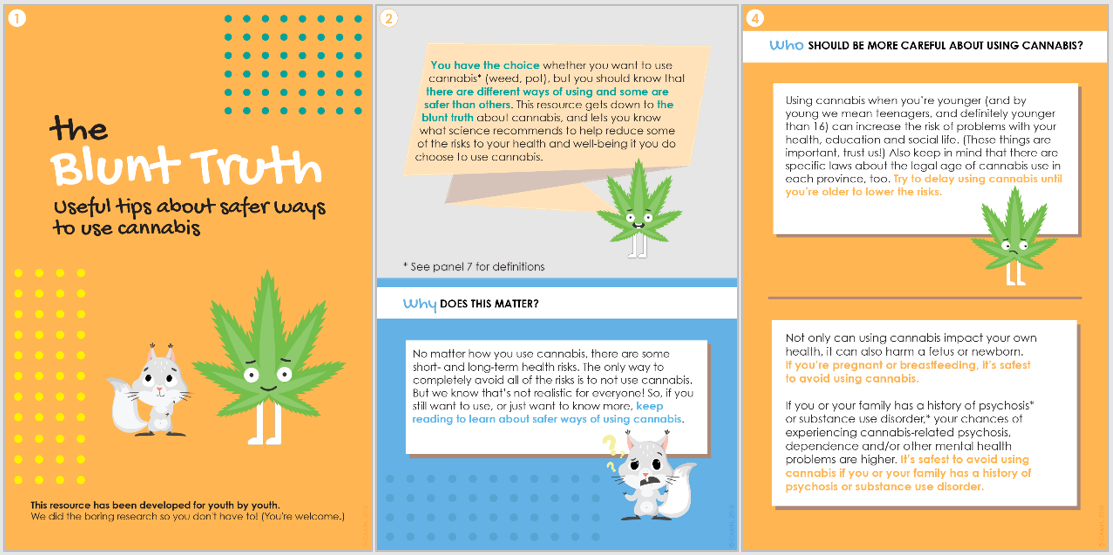
As a pillar in Canada’s national [drug strategy](https://www.canada.ca/en/health-canada/services/substance-use/canadian-drugs-substances-strategy.html), harm reduction is a key ingredient of effective efforts to address youth substance use. Harm reduction efforts aim to reduce the potential social and health harms related to substance use, without necessarily promoting or requiring non-use. This is in contrast to abstinence-based approaches, which reflect the belief that avoiding substance use entirely is the only acceptable and safe option for individuals. Examples of abstinence-based initiatives include “just say no” campaigns and the school-based program Drug Abuse Resistance Education (DARE). These and other abstinence-based prevention initiatives have been evaluated extensively and show limited effectiveness. Harm reduction and abstinence-based approaches differ in how they measure success and the range of choices individuals can exercise when it comes to their substance use (see example in **Box 3**).

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| **Box 3.** A hypothetical scenario demonstrating key differences between harm reduction and abstinence approaches.  The weekend after taking part in a substance use education initiative at his school, Simon, a grade 12 student, is getting ready for a party. Normally, Simon drinks a 26-oz bottle of liquor at parties, and often does not remember much of the night and has a terrible hangover afterwards. This time, Simon decides to bring a six-pack of beer with him to the party, so he can still “have a good time” with his friends but still remember the events of the night and not feel awful the next day. Simon also arranges for a designated driver, his older sister, to get him home safely.  From an abstinence perspective, the substance use initiative would be considered *ineffective*, since it did not discourage Simon from drinking at the party. From a harm reduction perspective, the initiative may be considered *effective*, since Simon took purposeful measures to keep himself and others safe when he was using alcohol (i.e., by choosing a lower alcohol by volume beverage and finding an alternative to drinking and driving). This example illustrates differences in how “success” is defined between harm reduction and abstinence-focused approaches. |

A central part of harm reduction is the understanding that individuals vary in their experience with substance use and openness to support or change. Given these realities, harm reduction initiatives present people with various options that enable better health, while still reflecting their unique wants, needs and values at a given time. Harm reduction efforts support healthy behaviours without “forcing” them and celebrate even the smallest positive behaviour changes, recognizing that each is a step towards improved health and well-being. By “meeting people where they are at”, effective harm reduction initiatives respond to the needs of *all* people, including those who do not use substances, use substances occasionally or frequently or have a substance use disorder. Because of this, harm reduction is an inclusive and pragmatic approach to preventing substance-related harms among youth.

A growing number of school communities in Canada and abroad are implementing harm reduction-focused initiatives with the aim of reducing substance-related harms, rather than the amount or frequency of substance use directly. An example is drug education that shares with students practical, effective strategies for reducing potential health effects associated with using certain substances (as shown in **Figure 3**). School-based harm reduction initiatives can have positive impacts on students’ knowledge, attitudes and behaviours related to substance use, and can promote less harmful substance use. These outcomes may be explained in part by students’ receptiveness to harm reduction messaging. Research shows that youth perceive harm reduction drug education as more helpful and practical than abstinence-focused drug education, since many youth have used or *will* use substances to some extent and already apply harm reduction strategies in their own lives. Additionally, many studies prove that harm reduction efforts do not encourage youth to experiment with substance use.

Shifting to a harm reduction approach can also help prevent social harms related to substance use. For example, harm reduction-oriented school policies seek to connect students to various supports to help manage their substance use or address underlying causes (e.g., counselling, harm reduction or treatment services), with the goal of facilitating health and well-being. On the other hand, abstinence-oriented school policies most often encourage punishment (e.g., suspension or expulsion) of students who use substances, which can push them further from support, opportunity and their larger community. These punitive actions can have long-lasting and avoidable negative social consequences.



**Figure 3.** Excerpts from Centre for Addiction and Mental Health’s [*The Blunt Truth*](https://www.camh.ca/en/health-info/guides-and-publications/lrcug-for-youth), a harm reduction-focused cannabis education resource developed for and by youth.

Harm reduction is an evidence-based approach that respects and promotes human rights and can be expressed through a wide range of policies, programs, services and education efforts. The figure below outlines examples of school-based harm reduction initiatives, across the four components of the Comprehensive School Health framework.

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|  | **Harm reduction** |
| **Teaching and Learning** | * Sharing youth-specific recommendations within Canada’s Low-Risk Alcohol Drinking Guidelines and Lower-Risk Cannabis Use Guidelines through posters, class discussions, pamphlets, etc. * Using a “train-the-trainer” model to equip youth with the knowledge and skills they need to facilitate safe, non-stigmatizing discussions on harm reduction strategies that students have used or seen in their own lives to enable peer-to-peer sharing and validation of these strategies. * Hosting school community-wide information sessions on the Good Samaritan Act, emphasizing its central public health and safety objectives. |
| **Social and Physical Environment** | * Displaying print materials designed by students (e.g., meme posters) that feature harm reduction messaging in common spaces within the school, such as hallways and the main office. * Installing safe disposal containers that school community members can access to safely dispose of needles, razors, broken glass or other “sharps”. |
| **Policy** | * Review existing school policies to identify policies already in place that align with and can help to support harm reduction-oriented initiatives and objectives within the school community. * Creating school-level Good Samaritan policies that prevent the punishment (i.e., via suspension, expulsion, etc.) of students or other members of the school community who call for emergency help in response to a potential substance use poisoning or overdose on school property. * Empowering teachers to create their own “small p” harm reduction-oriented policies for their classroom, such as a policy that encourages students to speak with their teacher before or after class if they are struggling with their substance use and without fear of reprisal or punishment. |
| **Partnerships and Services** | * Inviting local pharmacists into the school to give a presentation on how to effectively recognize and respond to a suspected opioid poisoning and about naloxone kits (i.e., what these kits are, how to use them, where to get them in the local community, etc.). * Partnering with local public health nurses working in harm reduction service centres (e.g., supervised consumption sites, managed alcohol programs, etc.) to increase youths’ awareness and understanding of these services that exist in their community. |

## Stigma reduction Initiatives

Many health experts and advocates agree that stigma reduction must be a core objective in any plan or strategy to prevent substance-related harm. Stigma begins with the negative stereotyping of people, creating separations in “us” vs. “them”.  These separations may relate to parts of people’s *identities*, like their age, ethnicity, nationality, culture, gender or LGBTQ2+ identity. Certain *behaviours*, like substance use, are also stigmatized in society, as are many *health conditions*, including substance use disorders and mental illness. People can also experience *intersecting* stigmas, which is when several aspects of one’s identity are stigmatized (e.g., in the case of a racialized trans youth living with a mental illness).

Stigma prevents us seeing people as full, complex human beings, and treating them as such. The Chief Public Health Officer's [2019 Report on the State of Public Health in Canada](https://www.canada.ca/en/public-health/corporate/publications/chief-public-health-officer-reports-state-public-health-canada/addressing-stigma-toward-more-inclusive-health-system.html) outlines how stigma is a pressing public health and social justice concern, and one that demands a widespread response across sectors and segments of the population. The report also describes substance use stigma, including its “root causes”, how it is expressed and its impact on substance-related harms and other negative consequences. **Box 4** summarizes the many forms of substance use stigma.

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| **Box 4.** Forms of substance use stigma.  Substance use stigma can be expressed in many forms. A significant, though sometimes subtle, form of substance use stigma is systemic stigma. This form of stigma can be seen in the education system within policies, practices, staff training and institutional culture. Examples include substance use curricula that emphasizes personal choice and responsibility and punitive zero-tolerance policies. Given its often invisible nature, decision-makers, teachers and other staff in the school system may enact systemic stigma unknowingly. Systemic substance use stigma also exists in the health, housing and child welfare systems, and elsewhere.  Systemic stigma reinforces and is reinforced by public stigma. Expressions of public stigma include avoidance, blame and judgment of people who use substances, through both actions and words. Public stigma can prevent important dialogue about substance use, including ways to minimize potential harms. A key driver of public stigma is the view that substance use and its related harms are the result of individual choice, immorality and/or a lack of willpower. Public stigma related to substance use can emanate from local communities and even within families in which a member has a substance use disorder or otherwise uses substances.  Stigma can also be internalized among people who use substances, leading to shame, low self-esteem, social avoidance and a lack of willingness to talk about their substance use or to seek help. These are examples of how self-stigma can be expressed. |

Stigma reduction efforts are highly relevant and beneficial in school contexts. These efforts make space for open, informed and non-judgmental conversations about substance use, as well as other stigmatized behaviours, health conditions or identities. It is natural and even expected for youth to have questions about substance use. Unfortunately, these conversations remain taboo in some school communities (i.e., due to staff’s discomfort with the subject matter, students’ fear of punishment, etc.). For this reason, many youth must seek other sources of information, such as social media and the internet, and sometimes without the knowledge and skills to assess which information is credible. Stigma reduction efforts create opportunities for school community members to exchange credible, practical information and advice about substance use, which can facilitate more informed or lower-risk behaviour.

Creating safe, stigma-free spaces can also encourage individuals to ask for help related to substance use and to know where to access available harm reduction or treatment supports. Stigma is a major barrier to help-seeking, and purposeful efforts to reduce stigma can begin to bring these barriers down.

Stigma reduction efforts can help to enhance important socio-emotional assets and skills, such as empathy, sensitivity and compassion. In doing so, these efforts can work to undo the divisions of “us vs. them” and dehumanization that often come with various forms of stigma. These practices get in the way of people accessing important resources, building and sustaining healthy relationships and, ultimately, reaching their full potential. In this way, stigma negatively impacts individuals, their communities and society more broadly. For these reasons, stigma reduction efforts have broad relevance and everyone has a role in ending stigma, including school communities.

Shown below are various examples of stigma reduction initiatives, across the four components of the Comprehensive School Health framework.

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|  | **Stigma reduction** |
| **Teaching and Learning** | * Creating classroom activities that counter common misconceptions and about substance use (e.g., that substance use disorder is a personal choice) and stereotypes about people who use drugs, while enhancing substance use literacy, as a part of school health curricula. * Teaching students about the importance of person-first language (e.g., “person who uses drugs” vs. “drug user”) and other strategies for reducing stigmatizing language, and challenging students to “practice” these strategies through various class assessments. * Facilitating access to anti-racism, anti-homophobia/transphobia and anti-oppression and implicit/unconscious bias training for school staff and volunteers, given the intersections between substance use stigma and other forms of stigma. * Providing by-stander training to students to support them in safely intervening in situations of abusive, isolating, or stigmatizing behaviour online and in “real-life” contexts. |
| **Social and Physical Environment** | * Ensuring print materials and other media used or displayed within the school (e.g., posters, videos, etc.) do not portray substance use or people who use substances in demeaning, stereotypical ways that imply a certain “type” of person is more likely to use substances. * Designating “safe zones” in school communities where youth can ask questions and seek support for substance use-related issues without fear of reprisal or judgement, and identify these spaces with a poster or sticker (i.e., similar to the rainbow flag for LGBTQ2+ allies). |
| **Policy** | * Assessing existing school policies to identify policies already in place that aim to connect students and other members of the school community with supports related to their substance use, mental health or other aspects of their health and well-being. * Examining existing school policies to identify and revoke or reform policies that may perpetuate systemic substance use stigma, including punitive “zero-tolerance” policies, as well as policies that seek to ridicule substance use and promote fear and shame. * Developing protocols to identify members of the school community who show signs of a substance use disorder or may be at risk of substance-related harms and facilitating access to supports, and then broadcasting these protocols broadly (e.g., through parent-teacher night, team/club meetings, the school handbook, etc.). |
| **Partnerships and Services** | * Inviting people (e.g., young adults who recently were in school) with lived or living experience of substance use to give a presentation to students on their experiences, how stigma impacted them and strategies they used or currently use to support their health and well-being, and also to offer social support and mentorship to students. * Offering accessible workshops and learning opportunities for parents/families designed to increase understanding of substance use topics, mitigate stigma and help prepare them for discussing substance use with their children. |

## Equity-oriented Interventions

Certain populations are disproportionately impacted by substance-related harms and other negative social and health outcomes, making equity an important focus for effective substance use interventions. Equity is the absence of avoidable, unfair or fixable differences among groups of people, whether those groups are based on socio-economic, demographic or geographic characteristics. When we talk about supporting *health* equity, we mean working to give everyone a fair shot at reaching their full health potential and ensure no one is systematically disadvantaged from achieving this potential.

Equity is related to ‘equality’, although the two are distinct. The goal of equity is to understand and give people *what they need* to enjoy healthy, fulfilling lives. In contrast, the goal of equality is to ensure that everyone *gets the same things* to enjoy healthy, fulfilling lives. Both aim for fairness and justice, but equality can only achieve these things if we all start from the same place and have the same needs.

Equity-oriented interventions seek to make institutions and systems more accessible, responsive, compassionate and safer for all people. This is achieved, in part, by developing policies, programs and other interventions that reflect individuals’ diverse needs, preferences and life experiences. **Box 5** describes cultural safety and trauma- and violence-informed (TVI) practice, which are two examples of intervention approaches that centre on promoting equity.

|  |
| --- |
| **Box 5.** Examples of intervention approaches that focus on promoting social and health equity.  Cultural safety: The goal of cultural safety is to ensure that institutions and services are safe (physically, emotionally, spiritually, socially, etc.) for those of all cultural groups and do not deny people their identity or culture. Cultural safety represents an ongoing commitment to try to understand how one’s culture may influence their needs, values, preferences and situation, and using this understanding to support individuals to reach their full potential. This is done in part by acknowledging, respecting and “making space” for all people, regardless of their expressed or assumed culture or identities. Cultural safety is especially important for those who identify as Indigenous but is relevant for other populations that face multiple barriers, including transgender individuals and members of racialized communities.  Trauma- and violence-informed (TVI) practice: There is a growing recognition that experiences of trauma and violence - both interpersonal and systemic - are common and can have a lasting impact on individuals’ development and behaviour. This understanding has led to the emergence of TVI practice. The goal of TVI practice is to prevent the escalation of harm and avoid re-traumatizing people by creating safe spaces that foster compassion and collaboration to build on strengths to support resilience and coping. A key part of this is shifting one’s thinking from “what’s wrong with you?” to “what happened to you?” in response to unexpected or undesired behaviour (e.g., aggression, inattention, etc.). TVI practice can be woven into policy, everyday practices, changes to the physical environment and education efforts. |

Equity-oriented interventions are recognized for their ability to counteract various forms of stigma and discrimination and preventing substance-related harms, in [health systems](https://www.canada.ca/en/public-health/services/publications/healthy-living/primer-reduce-substance-use-stigma-health-system.html#_5.1) and elsewhere. However, they can also yield unique social and learning benefits within school communities. For example, teachers and other school community members can help set students of all cultural backgrounds up for academic success when they cultivate culturally safe learning and social environments. This involves understanding how culture can shape many aspects of one’s life (i.e., leading to differences in ways of seeing, knowing and doing) and validating individuals’ experiences and identities. Likewise, the shift in thinking from “what’s wrong with you?” to “what happened to you?” that is central to TVI practice can help adults within the school community to better understand the complex factors that shape youths’ behaviour (e.g., “acting out” at school). An equity “lens” can help adults to be more in touch with what students need to be successful, rather than simply writing them off as a “bad kid”.

All school communities, no matter the demographics, can strive to be more equity-oriented. Further, both cultural safety and TVI practice do not require formal training or specialized knowledge to implement, and both models can involve relatively simple strategies. These include person-centred communication (e.g., asking students what can be done to make them more comfortable or support their learning) and efforts to make the school environment calmer and more inviting.

The figure below lists examples of specific equity-oriented initiatives, particularly those related to TVI and cultural safety, across the four components of the Comprehensive School Health framework.

|  |  |
| --- | --- |
|  | **Equity-oriented interventions** |
| **Teaching and Learning** | * Educating students on Indigenous history, including the multigenerational impacts of colonization and colonialism and the resilience of Indigenous peoples in Canada, reflecting and building on school curricula in these areas. * Educating members of the school community on the impact adverse childhood experiences and trauma have on an individual’s brain development, learning and social interactions with others, through use of the [Brain Story toolkit](https://www.albertafamilywellness.org/brain-story-tookit) and other evidence-based resources. * Providing workshops or education material to deepen understanding of the many cultural groups that are represented in the school and how to provide culturally safe care/education. * Ensuring educators are familiar with students’ unique backgrounds to provide education based on needs (i.e., being familiar with a student’s Individualized Education Plan, speaking with school counsellor or social worker, etc.). |
| **Social and Physical environment** | * Ensuring all students have a work environment that is conducive to their unique needs (i.e., quiet areas, music, lighting, other elements of a sensory-friendly environment, etc.) and working with students to ensure their environment is beneficial to their needs. * Cultivating physical environments that invite students of all genders, races, sexual orientations, cultural groups, abilities and social classes to feel safe and welcome (e.g., Gay-Straight Alliance clubs). * Ensuring the school and surrounding area is accessible for all students (e.g., through installing ramps and elevators, giving students extra time to get to class or activities). |
| **Policy** | * Assessing existing school policies to identify those that support equity and help to address inequities related to health or social matters. * Designing policies that integrate the unique and diverse views and needs of students so they are expected and respected (i.e., some students may celebrate different holidays or have different ways to celebrate holidays, such as fasting, silence and praying). * Adapting policies to be more equity-oriented (i.e., removing disciplinary policies that may re-traumatize students, allowing different styles of learning and testing, etc.). * Applying a Gender-Based Analysis (GBA) + approach to policy development and review. * Increasing diversity and representation across teaching and administrative staff within the school community. |
| **Partnerships and Services** | * Supporting students and other school community members to participate in the KAIROS Blanket Exercise program, which seeks to foster truth, understanding, respect and reconciliation among Indigenous and non-Indigenous peoples. * Facilitating school trips, in collaboration with local Indigenous groups that enable student to attend Indigenous pow-wows, ceremonies, feasts, etc. * Engaging with local Native Friendship Centres for land-based education opportunities with local leaders. |

## Combining the intervention approaches

Each of the four intervention approaches outlined above – upstream prevention, harm reduction, stigma reduction initiatives and equity-oriented approaches – has numerous benefits and is supported by evidence. What’s more, each can be operationalized in many ways within Canadian school communities, including through application of the Comprehensive School Health framework.

These approaches are often portrayed as discrete, given their differing focus, objectives, origins and current level of adoption within school communities. Additionally, *School Matters* participants described the tension that exists between the approaches, including how approaches are sometimes pitted against another and posed as mutually exclusive. For example, participants noted the perception that it is impossible to “do” both upstream prevention and harm reduction concurrently within school contexts.

However, in reality, the four approaches are more similar than distinct. They share the same values of compassion, equity and responsiveness to what individuals need to reach their full potential. In addition to these shared values, the four intervention approaches captured within the Blueprint can all work towards the goal of preventing and reducing substance-related harms among youth. The approaches can even “look” the same in practice, as highlighted during a group activity at the *School Matters* forum. After learning about each approach from experts in the field, participants were asked to brainstorm how each approach could be put into practice across the four components of the Comprehensive School Health. Frequently, there was overlap in the types of initiatives that groups of participants identified across different intervention approaches. For example, groups indicated that peer support and mentorship programs can be instrumental in advancing upstream prevention, harm reduction, stigma reduction and equity-oriented interventions within school communities.

It is for these reasons why the Blueprint intervention model brings together all four approaches and depicts them on equal “footing” and as complementary, versus stand-alone, means of preventing substance-related harms. The inter-relation between the approaches is emphasized in the model through the dashed lines in the matrix. The model is also meant to show how the cells of the matrix represent “building blocks” that can be combined to form a strong and holistic strategy for preventing substance-related harms within school communities by having a broad range of approaches represented, as shown in **Appendix 1**,

When planning and combining these approaches (e.g., within a school community action plan or school board-level strategy), it is critical that the interventions are tailored to reflect the unique values, needs and resources of the school communities for which they are intended. This can be supported by actively engaging with members of the school community (e.g., students, families, staff, community partners, etc.). Meaningful engagement of this kind can help to ensure that initiatives are practical, relevant and sustainable. This is described more in the “Principles for Action” outlined in **Section 3**. There is also a variety of practical tools available intended to help school communities in identifying and assessing their unique needs and planning school health initiatives accordingly (see **Appendix 2**).

## Strengths of the Blueprint for Action model

There are many reasons why the Blueprint intervention model is relevant, feasible and actionable in the context of Canadian school communities:

1. **The model affords greater reach and resonance with youth compared to “one-size-fits-all” models.** Youth differ tremendously in their identities, substance use experience, interests, learning styles and their broader life situation (e.g., family and home context, socio-economic status, etc.), among other factors. These differences are not appreciated in “one-size-fits-all” models for addressing substance use; various approaches are needed to resonate with and reflect the needs of the student body as a whole.
2. **When applied in combination, the “building blocks” can support and reinforce each other.** Given the similarities that exist across the intervention approaches, when applied together, they send a consistent message to students, families, partners and others about the school community’s commitment to promoting health and well-being and addressing substance use as an important health issue. This message is further solidified when the approaches are reflected within the various components of the Comprehensive School Health framework.
3. **The four intervention approaches have broad relevance.** The four approaches featured in the Blueprint model are far from “niche”; they have a place within any school community, and schools have flexibility to tailor them to meet their unique context and needs. In this way, the Blueprint can be a useful tool in schools in rural and remote communities, as well as in large urban centres, and everything in between, Further, the four approaches are already “in play” within many school communities to some extent, often without being explicitly linked to the prevention of substance-related harms.
4. **The model can contribute to a *range* of positive outcomes for school communities**. Given the intervention approaches’ diverse aims, adopting them in combination is likely to yield numerous positive impacts for students and the broader school community, above and beyond those specific to substance use. These may include greater school connectedness, enhanced resilience and mental well-being among students and improved relationships between students and staff.
5. **The model reflects a much-needed shift away from the “status quo”.** Substance use patterns, policies and concerns evolve rapidly with time, as does our understanding of how these factors impact substance-related harms and evidence for how to best intervene. Our dialogue and action related to youth substance use must shift in accordance with these developments. The Blueprint model reflects a contemporary, evidence-informed and holistic means of addressing substance use within school communities, and one that compensates for the shortcomings of existing approaches.

The *School Matters* participants noted these, and many other, potential strengths of the Blueprint model. Some participants also described how the model could serve as a national catalyst for shifting dialogue and action related to youth substance use within school communities, mirroring similar changes in other contexts (e.g., the health system). While this section focused on the conceptual aspects of the model and its components, **Section 3** delves into the practicalities of the model applied within “real-world” school communities, with further insights from *School Matters* school stakeholders.

# Section 3: Putting the Blueprint for Action into practice

**Section 3** focuses on the application of the Blueprint model in practice. Much of this section’s content reflects key learnings and discussions from the *School Matters* forum. Participants identified various factors that can either *support* or *inhibit* school communities as they work to apply the Blueprint model and carry out comprehensive, evidence-based initiatives to prevent substance-related harms. This section also outlines cross-cutting principles for action that school communities are encouraged to consider when planning and delivering interventions intended to help prevent substance-related harms.

[CREATIVE SERVICES TO INSERT IMAGE HERE]

## Facilitators that can support school communities in applying the Blueprint model

There are many factors, both assets and actions, that can support school communities in effectively applying the Blueprint model, and in their efforts to prevent substance-related harms more generally.

**Highly engaged, well-supported people who value and prioritize school community members’ health and well-being.** The existence and effectiveness of school health and well-being initiatives rely heavily on the “champions” within the school who can get these initiatives off the ground and in ways that generates interest and buy-in from other members of the school community. Champions may include teachers, parent council members, school public health nurses and school trustees, among others. In particular, youth have (often untapped) expertise, energy and ideas to develop and lead high quality health and well-being initiatives (e.g., peer support and student ambassador programs). In all cases, it is important that these people have the support of administrators and other decision-makers. This support may include training, funding and a general openness to new ways of doing and trust in school community members’ capacity and understanding of students’ needs, preferences and values.

**Strategic and diverse partnerships that school community members invest in and develop over time.** Strong partnerships are those that draw on the unique expertise, experiences and resources of each party. These partnerships take time and energy to develop. Potential partners for school communities include local businesses, public health authorities, regional youth or school health organizations and other school communities. Partnerships can facilitate capacity building, sharing of resources and promising practices and collaboration on shared initiatives. Specific examples of how partnerships can be leveraged include community “task forces” dedicated to preventing substance-related harms and mentorship programs that connect students to recent graduates for social support and guidance.

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**Accessible, practical and relevant resources and supports.** These include those focused on substance use, as well as related topics, like socio-emotional learning and mental health. Examples of these resources are included in **Appendix 2**. Resources are most useful when they align with existing structures and practices within the school community (e.g., provincial curricula) and are not “add ons”. Resources and supports can be developed “in house” to be tailored to a school communities’ unique context or sourced externally, such as from community partners or public health organizations. Another very practical facilitator for action is designated funding to support comprehensive and innovative approaches to preventing substance-related harms.

**Thoughtful, strategic processes (standard ways of “doing”) that maximize the impact of efforts to prevent substance-related harms within school communities.** These processes include relatively simple things like communicating school policies, programs and supports related to substance use to students and families through various means (e.g., assemblies, school handbooks, class discussions, etc.) and throughout the school year. They also include more systems-level processes. One example is the process of embedding topics on substance use and mental health in required training for pre-service teachers and ongoing staff professional development opportunities. Another example is piloting innovative practices on a small-scale (i.e., individual classes or schools) and scaling up when they show promise.

**Contextual factors that *support* school communities in advancing innovative and comprehensive approaches to preventing substance-related harms.** These factors include greater public awareness and dialogue about substance use (framed as a health, versus criminal, issue) and changes in policy and practice at various levels of government that support people who use drugs and mitigate stigma. Additionally, a healthy school environment, where there is a positive atmosphere, trusting and supportive relationships between staff and students and invested parents, is key for generating momentum and support for advancing the intervention approaches outlined in this Blueprint. In these ways, a healthy school environment is an essential component of broader population-level efforts to prevent substance-related harms among youth.

## Barriers to implementing the Blueprint model within school communities

Several factors may inhibit school communities from implementing comprehensive approaches to preventing substance-related harms (such as those detailed in this resource) or limit the effectiveness of these efforts. Many of these factors reflect ongoing challenges that school communities face when it comes to planning and carrying out health initiatives in general.

**Pushback and lack of capacity within school communities.** For various reasons, school communities may be resistant to new ways of addressing youth substance use. These include fear of pushback for discussing certain substance use topics with students (e.g., lower-risk use), a lack of understanding of the different intervention approaches and thinking that these efforts fall outside of the school’s “lane”. A lack of representation and diversity at decision-making tables can pose additional challenges for introducing and getting support for novel approaches. School communities may also have challenges with capacity. These may stem from high turnover (in staff, students, community partners, etc.), limitations in staff training and the numerous competing priorities that school communities must juggle.

**Various obstacles that get in the way of fruitful partnerships.** One major obstacle is a lack of clear, shared objectives and different interpretations of the “problem” to be addressed around youth substance use. There are also more general obstacles to forming meaningful partnerships. These include limited dedicated resources (time, funds, etc.) required to develop these partnerships, unrealistic expectations for immediate outputs and results from these relationships and resource limitations that incentivize competition over collaboration among potential partners. Likewise, siloing across different sectors and disciplines can get in the way of forming “unconventional”, but beneficial, partnerships.

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**Limitations in the accessibility and availability of relevant resources.** Given the dominance of abstinence-oriented drug education in previous decades, there exist relatively few harm reduction-focused drug education resources for youth audiences. Likewise, resources on stigma reduction and different equity-oriented approaches (e.g., trauma- and violence-informed care) that are designed for school contexts are not yet “mainstream”, making related resources difficult for school communities to find. Similar challenges include limited capacity to “vet” resources, a lack of awareness of resources, and conversely, being overwhelmed by the volume of resources and not knowing “where to begin”.

**Challenges in planning and carrying out relevant and impactful substance use initiatives.** These include the tendency to pursue “low hanging fruit” and maintain the status quo, rather than making more strides towards comprehensive approaches to preventing substance-related harms. There is also the practical issue of staying on top of evolving trends in how youth communicate and substance use patterns. These create challenges for keeping youth-focused initiatives engaging, timely and relevant.

**Contextual factors that *inhibit* school communities from advancing innovative and comprehensive approaches to preventing substance-related harms.** These factors include risk aversion, limited readiness for change and a lack of political will at various levels of the school system (e.g., administrators, school boards, departments of education, etc.). These factors may relate to widespread substance use stigma and deeply entrenched beliefs within some school communities that abstinence and prohibition are necessary to protect youth from substance-related harms. Other contextual factors such as a lack of social capital, income inequality, limited access to important social resources (e.g., childcare, secure and safe job opportunities, etc.) and other social determinants of health may also interfere with school communities’ ability to organize, fund and support these approaches.

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Though the specific facilitators and barriers school communities experience may vary over time and from one context to the next, the factors identified above provide helpful considerations for school communities looking to apply the Blueprint model. These considerations can help in identifying things to strive for and maintain (in the case of facilitators), as well as factors to plan around and mitigate (in the case of barriers). These insights can support schools as they work to apply the model in practice.

## Principles for Action

While the Blueprint model can help school communities to identify *what* actions they can take to prevent substance-related harms, the five principles outlined in this section describe *how* they can effectively work towards this objective. The principles are over-arching and relevant to any initiative designed to prevent substance-related harms among youth. Below is a summary of these principles; they are unpacked in greater detail in the accompanying policy paper [LINK].

***Principle #1:*** *Base all initiatives on evidence of what works or shows promise of working.*

Certain “go-to” approaches for addressing substance use have limited effectiveness and can even produce unintended negative consequences. School communities should ensure that their intervention planning and delivery is grounded in the best available evidence (including practice-based evidence) and regularly evaluate the success of their efforts, instead of merely accepting and repeating the status quo.

***Principle #2:*** *Apply a strong health equity lens to inform prevention efforts.*

Many sub-groups of Canadian youth are disproportionately and negatively impacted by substance-related harms, as a result of ongoing systemic policies, practices and behaviours that disadvantage some youth. These sub-groups include Indigenous youth, youth in the child welfare system and LGBTQ2+ youth, among others. Applying a health equity lens means not losing sight of these priority populations and designing prevention efforts that reflect an understanding of their unique context and needs. It also means acknowledging and helping to dismantle socially determined barriers to health and well-being, such as those associated with gender, socio-economic status, race, LGBTQ2+ identity and stigma.

***Principle #3:*** *Advance compassionate, non-judgemental and strength-based approaches that include engaging with and listening to people with lived and living experience of substance use.*

Interventions intended to prevent substance-related harms among youth are greatly strengthened by meaningful engagement of youth (a vital player within school communities), including those with lived experience of substance use. School communities should design interventions that leverage youths’ many strengths and enhance their resilience, instead of trying to “fix” their shortcomings. They should also explicitly aim to counter and reduce substance use stigma and promote compassion.

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***Principle #4:*** *Incorporate harm reduction principles within school initiatives in order to prevent and reduce substance-related harms among youth who currently use, or may use, substances.*

Substance-related harms are not fixed or “a given"; they can be reduced through harm reduction efforts at individual- and school community-levels. As described in **Section 2**, harm reduction is a pragmatic and equitable approach to preventing substance-related harms among youth, and can be operationalized through policies, education and services within school communities, among other initiatives.

***Principle #5:*** *Collaborate across sectors and at multiple levels, including individual, community and structural levels (e.g., housing, social services, and health care).*

Many of the “root causes” of substance-related harms extend beyond the reach of the education sector (or *any* one sector, for that matter), underscoring the need for a collective response to help prevent substance-related harms. School communities are encouraged to build and strengthen partnerships across various sectors (e.g., health, public safety, local businesses, academia, etc.) and at various “levels” (e.g., individuals, families, local communities and governments) with the shared goal of promoting health and well-being and preventing substance-related harms. Strong partnerships and ongoing collaboration also increase the likelihood that interventions are comprehensive and sustainable.

# Conclusion

School communities have a vested interest in the health and well-being of youth, including their risk of experiencing substance-related harms. This resource presents the Blueprint for Action intervention model - a tool that school communities can use to inform and strengthen their efforts to prevent substance-related harms among youth. Through thoughtful application and evaluation of this model, school stakeholders can help to support positive shifts in how school communities address substance use, and ultimately, their ability to effectively respond to and prevent substance-related harms.

# Appendices

## Appendix 1. **The Blueprint for Action model “in practice”**

The figure below shows an example of how school communities can use the Blueprint for Action model to plot out various intervention strategies to bring together (e.g., in a school action plan) as a part of a school community’s comprehensive approach to preventing substance-related harms.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  | **Substance Use Intervention Approaches** | | | |
|  |  | **Upstream prevention** | **Harm reduction** | **Stigma reduction** | **Equity-oriented interventions** |
| **Comprehensive School Health Framework Components** | **Teaching and Learning** |  |  |  | Offering diversity and inclusivity training for students and staff to increase knowledge of the diverse identities and situations that contribute to an individual’s unique lived experience. |
| **Social and Physical Environment** | Providing resources, encouragement and space to students who are keen to start a new club or student group, organize events, etc. |  |  |  |
| **Policy** |  | Establishing school-board level policies that require schools to have naloxone kits available and accessible in the event of a suspected opioid poisoning. |  |  |
| **Partnerships and Services** |  |  | Partnering with local substance use counsellors to facilitate access to specialized support to students who use substances. |  |

## **Appendix 2.** Additional resources & research articles

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### Equity-oriented interventions

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1. By **youth**, we are referring to individuals in the period of transition from the dependence of childhood to adulthood’s independence. Given that this transition can take place at different points in time, depending on the individual, there are no specific age limits on who may be considered a “youth”. [↑](#footnote-ref-1)
2. The term **interventions** describes the programs, policies, practices and other initiatives carried out to address a particular social or health issue. [↑](#footnote-ref-2)
3. The term **practice-based evidence** describes evidence that is generated primarily from practice and lived experience, as opposed to peer-reviewed empirical research. Practice-based evidence has particular relevance in the context of emerging intervention areas (i.e., given the lag between an intervention being implemented and later being supported by “top-tier” evidence, such as evidence from systematic reviews), as well as within cultures and communities in which storytelling and the wisdom and experience of Elders are highly valued. [↑](#footnote-ref-3)
4. By **levers**, we mean different ways of operationalizing or carrying out an approach. Examples of intervention levers include education, policy and changes to the physical environment. As detailed in this section, the Comprehensive School Health framework is a common model that emphasizes the various levers school communities can use to address health and well-being issues. [↑](#footnote-ref-4)